



TO: Middletown City School District Full-time Employees

FROM: Elizabeth McKean
Assistant Superintendent for Administration

RE: FLEX 125 PLAN

DATE: October 24, 2011

The Middletown City School District's Flexible Compensation Program's Plan Year will end on 12/31/11. It is now time for all full-time employees to do three things:

1. If you contributed to a Health Care Flexible Spending Account, please be sure to use up your account balance. Claims for unreimbursed medical expenses incurred prior to 12/31/11 can be submitted up until 3/31/12. After that date, any amounts left in your account will be forfeited. If you want to check the status of your account, call Fitzharris Administrators at 1-800-321-1336.
2. Attached is an Election Form for the Plan Year 1/1/12 to 12/31/12. Now is the time to start thinking about medical, dental, vision care, etc., expenses you may have coming up which will not be reimbursed by our medical plans. The maximum annual deposit into your Flexible Spending Account cannot exceed \$3,000.
3. Dependent Care Spending Account - Allows you to set aside before taxes, money from your earnings to pay for dependent care services (day care, baby-sitting, elder care) that are necessary so you (or, if married, you and your spouse), can go to work. Note that the Dependent Care Spending Account cannot be used to pay for your dependent's health care expenses. You may elect to have salary reduction contributions, in an aggregate amount not to exceed \$5,000 per plan year, or in the case of married participants filing separately, \$2,500 per plan year.

Please return the election form to Linnette Chillino, Health Benefits Coordinator, at the Board Office by Friday, December 2, 2011. Election forms received after this date will NOT be accepted. Please contact Ms. Chillino at 326-1166 if you have any questions.

NOTE: *If you do not complete and return a new election form by Friday, December 2, 2011, your FLEX benefit coverage will end on December 31, 2011 and you will not be re-enrolled for the new 2012 calendar year.*

**MIDDLETOWN CITY SCHOOL DISTRICT
FLEXIBLE COMPENSATION PLAN
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT
PERIOD OF COVERAGE - 1/1/2012 THROUGH 12/31/2012**

Name (print) _____

Address _____

S.S. # _____

FLEXIBLE SPENDING ACCOUNTS

1. HEALTH REIMBURSEMENT ACCOUNT

() I hereby elect to make the following annual contribution to my Health Care Flexible Spending Account under the Plan and hereby agree that the annual contribution will be made in equal amounts each pay period through payroll deduction:

\$_____ total for the plan year. \$_____ for each pay period.

Note: The annual deposit in the Health Care Flexible Spending Account cannot exceed an amount of **\$3,000**.

2. DEPENDENT CARE ACCOUNT

() I hereby elect to make the following contribution to my Dependent Care Flexible Spending Account under the Plan and hereby agree that the annual contribution will be made in equal amounts each pay period, through payroll deduction:

\$_____ total for the plan year. \$_____ for each pay period.

Note: The annual deposit in your Dependent Care Flexible Spending Account cannot exceed **\$5,000**.
(\$2,500 for married participants who file separate returns.)

I understand that the above elections will remain in effect until that last day of the Period of Coverage noted above. I understand that I may change the above elections during the Period of Coverage noted above only if I experience a "status change", as defined under applicable law, and I may change my elections only in a manner consistent with that "status change". I understand further that if I do not complete and file a new Election Form during the next annual election period, the above elections will continue in effect until changed on a subsequent Election Form during a subsequent annual election period or until changed incident to a "status change" or a significant change in the coverage under the Plan. Finally, I understand that the elections noted above may need to be modified by the Employer to insure the Plan complies with applicable tax rules.

Date

Signature of Participant

HEALTH CARE SPENDING ACCOUNT

Claim For Reimbursement

| | | |
|------------------|------------------------|------|
| NAME OF EMPLOYER | | |
| EMPLOYEE NAME | SOCIAL SECURITY NUMBER | |
| EMPLOYEE ADDRESS | STREET | CITY |
| STATE | ZIP | |

HEALTH CARE EXPENSES

| NAME OF PERSON FOR WHOM HEALTH CARE SERVICE WAS PROVIDED | DATES OF SERVICE | | PROVIDER OF SERVICE | (A) TOTAL CHARGE | (B) AMOUNT PAID BY OTHER SOURCES | (A-B) AMOUNT TO BE REIMBURSED |
|--|------------------|----|---------------------|------------------|----------------------------------|-------------------------------|
| | FROM | TO | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| TOTALS | | | | | | |

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:

- They were incurred for services or supplies received by me or my eligible dependents under the plan.
- They were for services or supplies furnished while I was a participant in the Plan.
- I have not been reimbursed for these expenses and they are not reimbursable from any other health plan.

I understand that reimbursement of these expenses can be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered.

I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account.

I understand that reimbursement will be made in accordance with the provisions of the plan in which I participate. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

| | |
|--------------------|------|
| EMPLOYEE SIGNATURE | DATE |
|--------------------|------|

COMPLETION OF CLAIM FORM

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year.
- You must sign and date claim form.
- A copy of a bill or other written statement from the provider of service is acceptable only when **NO** other insurance is applicable.
- **If insurance is applicable, a statement from all medical/dental insurance carriers showing deductible and copayments is required.**

MAIL COMPLETED FORM TO:

FITZHARRIS & COMPANY, INC.

PO BOX 9182
 FARMINGDALE, NY 11735-9182
 (516) 777-2244 1-800-321-1336
 FAX (516) 777-5777/78

**DEPENDENT CARE SPENDING ACCOUNT
CLAIM FOR REIMBURSEMENT**

| | | |
|-------------------|------------------------|-------------|
| NAME OF EMPLOYER | | |
| NAME OF EMPLOYEE | SOCIAL SECURITY NUMBER | |
| EMPLOYEE ADDRESS: | STREET | CITY |
| STATE | ZIP | TELEPHONE # |

| <u>Dependent Name</u> | <u>Date of Birth</u> | <u>Relationship to Employee</u> |
|-----------------------|----------------------|---------------------------------|
|-----------------------|----------------------|---------------------------------|

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please complete the information below and attach corresponding bills or receipts with dates of service for each listed provider.

| | |
|----------------------------------|----------------------------------|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| Tax I.D. or Soc. Sec. #: _____ | Tax I.D. or Soc. Sec. #: _____ |
| Dates of Service: _____ to _____ | Dates of Service: _____ to _____ |

If dependent care was provided in your home, complete the following:

| | |
|---|----------|
| Household services Relating To the Care of a Qualifying Individual(s) | \$ _____ |
| FICA and FUTA Taxes on Wages Paid to a Housekeeper | \$ _____ |
| Room and Board Expenses Incurred Outside the Home for a Housekeeper | \$ _____ |
| Transportation Expenses of a Housekeeper | \$ _____ |
| _____ | \$ _____ |
| _____ | \$ _____ |
| _____ | \$ _____ |

If your eligible expenses were incurred outside of your home, complete the following:

| | |
|---|-----------------|
| Services Related to the Care of a Qualified Individual(s) | \$ _____ |
| Services Incurred in a Day Care Provider's Home/Center | \$ _____ |
| TOTAL DEPENDENT CARE REIMBURSEMENT REQUESTED: | \$ _____ |

I certify that I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the flexible spending account. I further declare that I have not and will not deduct these expenses on my individual income Tax Returns. I certify that the above eligible expenses have been (or will be) paid for the care of a qualified individual(s).

EMPLOYEE SIGNATURE _____ DATE _____

FITZHARRIS & COMPANY, INC.
P.O. BOX 9182
FARMINGDALE, NY 11735-9182
(516)777-2244 1(800) 321-1336
516-777-5777/78